GARFIELD HEIGHTS CITY SCHOOLS
SCHOOL ENTRANCE PHYSICAL EXAMINATION
(To be completed and signed by Physician)

School: ______________________ Grade: __________

Name of Child: ______________________ Birthdate: __________
mo./day/yr.

Heights: __________ Weight: __________ Blood Pressure: __________

General Appearance, Nutritional State:

	NORMAL	ABNORMAL		NORMAL	ABNORMAL	
Posture			Neck			Vision
Skin			Heart			R 20/
Eyes			Lungs			L 20/
Ears			Abdomen			Hearing test:
Nose			Genitalia			Type:
Throat (Tonsils)			Hernia			R._____
Mouth (Teeth)			Nervous System			L. _____
Musculoskeletal			Other (specify)			

Remarks and recommendations concerning any abnormal findings: ______________________
____
What medication, if any, is the child taking? ______________________
Reason for medication? ______________________
Was child referred to a specialist for any reason (specify): ______________________
____

SPECIAL TEST (At discretion of Physician)

Urinalysis: __________ Hemoglobin: __________ Other: __________

IMMUNIZATIONS (Give Month/Day/Year)

DPT: 1. __________ 2. __________ 3. __________ 4. __________ 5. __________
mo/day/year mo/day/year mo/day/year mo/day/year mo/day/year

POLIO: 1. __________ 2. __________ 3. __________ 4. __________ 5. __________
mo/day/year mo/day/year mo/day/year mo/day/year mo/day/year

MMR (on or after first birthday) 1. __________ MMR (before Kindergarten) 2. __________
mo/day/year mo/day/year

HIB: (Dates) __________ VARICELLA 1. __________ 2. __________
(Chicken Pox) mo/day/year mo/day/year (Before Kindergarten)

HEP. B.: 1. __________ 2. __________ 3. __________
mo/day/year mo/day/year mo/day/year

TUBERCULIN TEST (type): ______ Date: __________ Results: Positive Negative
Other (specify type and dates: ______________________

Tdap Booster: 1. __________ (**REQUIRED** for 7th grade entrance)
mo/day/year

Signature of Physician: ______________________ Date: __________
Physician Address: ______________________